

The Use of Book Clubs as a Therapy Method for Individuals with Aphasia

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by

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Abstract

This paper explores the idea of book clubs as treatment for individuals with aphasia. Before that discussion can begin, explanations of the field of speech-language pathology, evidence based practice, and the background of aphasia must be given. The speech pathologist is the main professional working with individuals with aphasia to help them regain communication and learn compensatory strategies for lost skills. Evidence based practice, researching in order to find support for treatment methods, is a crucial aspect of many health care related professions. Aphasia is a language disorder resulting from damage to the left hemisphere of the brain that can affect numerous language skills. Several programs are currently using aphasia book clubs including the Aphasia Center of California, the Rehabilitation Institute of Chicago, and speech pathologist Jennifer Triandafilou's private practice. By analyzing these programs, it can be found that book clubs have many advantages for the individuals with aphasia. Improvements and suggestions are also given at the end of the paper in order to strengthen future aphasia book clubs. Overall, this paper is meant to inform the audience about aphasia and support the treatment method of book clubs for individuals with aphasia.

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With any communication disorder, a discussion of which therapy method is most appropriate arises. Aphasia, a language disorder, is no exception. In order to provide the best services possible, speech-language pathologists and other professionals must research and evaluate the available therapy methods. Understanding what aphasia is, how to assess aphasia, and treatment philosophies will allow these professionals to develop beneficial services. It may be found, through research, that book clubs as group treatment are an effective therapy method for individuals with aphasia.

Description of Speech-Language Pathology

The field of speech-language pathology works to assess and treat a wide variety of communication disorders. These disorders can involve deficits in speech, language, social communication, cognitive skills, or swallowing. Speech disorders happen when a person cannot produce speech sounds or speak fluently. These two aspects greatly impact the person's ability to verbally communicate. Voice problems, such as vocal cord nodules, are also included in speech disorders. Language disorders are divided into two categories- expressive language and receptive language. Expressive language is the ability to verbalize thoughts and feelings. Receptive language is the ability to understand verbal messages being presented. A language disorder would then be any deficit in expressive language, receptive language, reading, or writing.

Social communication disorders involve the inability to understand and use verbal and nonverbal communication in social situations. These individuals may not be able to take turns in conversation or understand other's feelings. Cognitive skills are an important factor of communication. These skills include attention, memory, planning, and problem solving. If a person has deficits in cognitive skills, the speech pathologist will teach strategies to compensate

for the deficits. Lastly, swallowing disorders occur when an individual has difficulties with eating or swallowing. This requires specialized therapy to ensure safe swallowing (American Speech-Language-Hearing Association, 2015). Speech pathologists are imperative to the assessment and treatment of individuals dealing with these disorders.

Evidence Based Practice

Just as in other health care related fields, as speech pathologists work to better the profession, evidence based practice has come to the forefront of most practices. This idea is based around finding research to make informed decisions on how to treat a client. In other words, there should be evidence to support the therapy plan the speech pathologist selects. There is debate within the field about whether research should be the sole determining factor for therapy plans, or if information from the family and client are valid enough to create a therapy plan. Not only does evidence based practice support the therapy plan, it also is necessary for reimbursement and third party payers. Insurance companies require evidence that the therapy is beneficial to the individual and cost effective. These two reasons further validate the idea of evidence based practice.

In addition to the two discussed reasons for evidence based practice, there are many advantages to using it. First, it helps the education of speech-language pathology students become more than memorizing facts. Evidence based practice encourages staying up to date on research which would encourage students to learn from real life situations and studies rather than memorization. Second, evidence based practice parallels perfectly with the continuing education required of professionals. Part of continuing education can be researching or hearing speakers discuss the latest studies and results. Thirdly, like stated earlier, evidence based practice allows

for confidence in decision making. These decisions can then be supported and justified to clients, third party payers, referral sources such as physicians, and other professionals. Lastly, evidence based practice helps speech pathologists to focus primarily on the goals for the client. It is easy for speech pathologists to become distracted with paperwork and other administrative procedures; however, the focus should be on enhancing the client's communication in daily life. So, evidence based practice allows the speech pathologist to work to find the best methods to use for the goals created (Dodd, 2007). Research supports that evidence based practice is a beneficial method for speech pathologists to utilize.

When considering aphasia assessment and treatment, speech pathologists should consider incorporating evidence based practice. Therapy methods should be researched and trialed in order to select the best treatment method for an aphasic client. First, however, aphasia and the difficulties it brings about must be understood.

Background of Aphasia

Aphasia occurs from a dysfunction of the left hemisphere of the brain, the hemisphere that controls language. Aphasia is classified as a syndrome, a cluster of symptoms, not a disease. This syndrome presents itself differently in each individual; however, multiple aspects of language are typically affected. These aspects include comprehension, expression, reading, and writing. Difficulties in these areas can range from mild to severe based on the individual. Deficits can include difficulty with following directions, understanding conversation, retrieving words, decoding written words, and spelling.

Aphasia may also cause speech difficulties, specifically apraxia or dysarthria. Both apraxia and dysarthria are motor disorders of speech that differ in symptoms. Apraxia involves

an incoordination of planning and programming commands for sound production. Individuals with apraxia may struggle with word retrieval, groping when trying to speak, and inconsistent articulation errors. These difficulties worsen with longer speech utterances. On the other hand, dysarthria is a weakness in the muscles involved in speech production. Individuals with dysarthria have difficulties with slurred speech, consistent articulation errors, and voice impairments. These difficulties typically worsen when the individual is tired. Apraxia and dysarthria both impact the production of speech.

Aphasia is typically classified as fluent or non-fluent. In fluent aphasia, expressive language remains relatively intact and receptive language experiences difficulties. The individual will be able to say words; however, the words may not make sense together. One type of fluent aphasia is known as Wernicke's aphasia. Wernicke's aphasia is the name given because the area of the brain that is affected is called Wernicke's area. Wernicke's area is located where the temporal and parietal lobes of the brain meet. In non-fluent aphasia, receptive language remains relatively intact and expressive language experiences difficulties. These individuals know what they would like to communicate but are unsure how to actually say it. This can become frustrating because they can understand that they are not getting their message across to other people. One type of non-fluent aphasia is known as Broca's aphasia. Like Wernicke's aphasia, Broca's aphasia is the name given because the area of the brain that is affected is called Broca's area. Broca's area is located in the frontal lobe of the brain. Understanding these two categories of aphasia is important to assessment and treatment plans.

Assessment of Aphasia

When assessing an individual for aphasia, there are several criterion referenced materials as well as standardized tests. Criterion referenced materials are also known as skilled informal assessment. Skilled informal assessment allows the speech pathologist to identify strengths and weaknesses in the individual's language abilities. Examples of standardized tests are the Boston Diagnostic Examination of Aphasia (Goodglass, Kaplan, & Barresi, 2000), Minnesota Test for Differential Diagnosis of Aphasia (Schuell, 1996), and Western Aphasia Battery (Kertesz, 2006). The speech pathologist should research the psychometric measures of the tests before using them. In addition, the speech pathologist must select criterion referenced materials or standardized tests based on the individual's abilities and needs.

Whether the speech pathologist is using informal or formal testing, it is important to consider receptive language, expressive language, reading comprehension, written language, and cognition. The speech pathologist will elicit a series of tasks beginning with simple tasks and continuing in complexity until the individual reaches a point of breakdown. Once the individual has reached a point of breakdown, there is no need for the speech pathologist to attempt to elicit the more complex tasks. There are many ways to assess these different areas; the following are examples of one way to assess them. Receptive language should always be assessed first in order to determine if the individual will be able to understand the directions and questions the speech pathologist is asking during the rest of assessment. The first task includes assessing if the individual can follow one, two, and three step verbal directions. The speech pathologist may then ask the individual to identify objects and pictures. Next, the individual may be asked to comprehend sentences, narratives, and full texts. This can be done through the individual with aphasia listening to the content and then answering questions about general main points or

details. This assessment will allow the speech pathologist to examine if the individual has deficits in receptive language.

Assessing reading comprehension is similar to the tasks from assessing receptive language. The individual may be asked to read multiple step directions, words, sentences, or narratives. With directions and words, the speech pathologist will assess if the individual can comprehend what he or she is reading. With sentences and narratives, the speech pathologist can ask questions about the passage to check for comprehension. These tasks will assess if the individual can read and if he or she can comprehend written words.

The assessment of expressive language also involves a series of tasks. First, the speech pathologist may show the individual pictures or objects and ask him or her to name them. Then, the speech pathologist may show the individual pictures that tell a story and ask him or her to describe what was happening in the pictures using sentences. A sample of spontaneous language may also be collected. This can be done through simple conversation or completing an activity, such as a game, together. Fluency, the ability to speak easily and smoothly, may also be assessed throughout the assessment of expressive language. Expressive language assessment determines if the individual can verbalize thoughts and concepts.

To assess written language, the individual with aphasia may be asked to write a variety of tasks. First, the individual may be asked to copy figures and words. Then, the speech therapist may dictate words and sentences for the individual to write. Next, the individual may be asked to write self-generated sentences. Lastly, the speech pathologist may ask the individual to write biographical information such as his or her name and address. This assessment will examine if

the individual has the coordination to write and if he or she is able to process thoughts into written words.

Cognitive abilities should be assessed throughout the entire process. There are tasks that can specifically assess cognition; however, cognition is also involved in every other aspect assessed. Cognitive abilities to assess include problem solving, reasoning, memory, and attention. If these abilities are not assessed during other tasks, they can be assessed separately. For example, the speech pathologist could verbally list a series of five words and ask the individual to repeat them back in order to assess immediate memory (McGrath, 2014). Once all of these aspects of language are assessed, a treatment plan can be selected.

Treatment Philosophies

Historically, aphasia was a condition that was not commonly treated. During and after World War I, aphasia treatments were created for soldiers returning from battle. Many soldiers acquired aphasia due to head trauma from events such as gunshot wounds. Years later, during World War II, more programs were created for soldiers and additional programs were created for civilians. The professionals working in these programs believed that there was a small window in which improvement could be made. They believed that improvement could only occur during the first few days or weeks after acquiring aphasia. After World War II, aphasia programs began to focus on rehabilitation. The field of rehabilitative medicine grew and became influential, inspiring aphasia programs to become functional and multi-professional. In addition, more programs were created due to a booming population and influx of soldiers returning home (Sarno, 2004). Aphasia programs have developed throughout the years.

Today, as reimbursement for rehabilitation has become stricter, reimbursement for speech-language pathology services may decrease. In the case of aphasia, it is crucial to determine what goals to target in a short amount of time. Aphasia has lifelong effects on an individual that need to be continually treated. Even though insurance may not reimburse continual therapy, speech-language pathologists and other professionals are beginning to realize the need for ongoing support. It is important to understand that some clients with aphasia may not recover to full premorbid abilities. Professionals working with aphasiac clients may begin managing the communication difficulties only to discontinue services after ten sessions. Clients with aphasia deserve to have continuous treatment that alters based on the changes in the individual's life and abilities (Berstein-Ellis & Elman, 1999).

The speech pathologist is the primary professional treating the individual with aphasia. Speech pathologists are trained to work with aphasic individuals through schooling and further training at job sites. There are four main principles to include in aphasia therapy (McGrath, 2014). First, the speech pathologist should help the individual regain as much communication as possible. This involves helping the individual regain as much verbalization possible based on his or her abilities and level of aphasia. Second, the individual should learn compensatory strategies for the abilities that are not possible to regain. These strategies could include gestures, sign language, or augmentative communication. Examples of augmentative communication are picture exchange boards or electronic voice producers. Thirdly, the speech pathologist should help the individual cope with the deficits he or she must now live with. Aphasia has many psychosocial effects in addition to language deficits. Many times, individuals with aphasia become depressed as they discover the reality of their situation. The speech pathologist should be there to listen to the concerns of the individual and help him or her in any way possible. Fourth,

it is crucial that the speech pathologist educates the individual, family, and other professionals about aphasia and its deficits (McGrath, 2014). Regardless of the plan chosen, these principles should be included in therapy.

When selecting a therapy plan, speech pathologists must first think about individual therapy versus group therapy. Several studies have been done to determine if group therapy was an adequate way to treat aphasic individuals. Wertz and his colleagues performed a study to compare individual treatment and group treatment. A group of individuals with aphasia were randomly assigned to individual treatment or group treatment. Both groups received treatment for eight hours per week. They were given language tests both before and after the treatment period. No significant differences were found between the individual treatment pre and post language tests versus the group treatment pre and post language tests. However, Wertz did state that the individuals in group treatment made great improvement. He also stated that the group treatment was very cost effective. For these reasons, he urged speech pathologists to use group treatment as at least part of the aphasic individual's therapy plans (Elman, 1999).

Elman and Bernstein-Ellis also conducted research on how group treatment effected linguistic and communicative performance of the aphasic individuals. The twenty-three individuals in this study were the age of eighty years or younger, had chronic aphasia, and had received speech-language therapy previously. Participants were randomly assigned to one of two groups. The immediate treatment group received immediate assessment and immediate group treatment. The deferred treatment group received immediate assessment and deferred treatment. This group received treatment after the immediate treatment group received their four month treatment. The deferred treatment groups participated in other social activities, such as movement classes, during these four months.

The traditional materials used to measure the participants included the Shortened Porch Index of Communicative Abilities (SPICA; DiSimoni, Keith, & Barley, 1980), the Western Aphasia Battery (WAB; Kertesz, 2006), and the Communication Abilities in Daily Living (CADL; Holland, Frattali, & Fromm, 1999). The Communicative Effectiveness Index, the Affect Balance Scale, a connected speech sample, interview data, and a conversation about television shows were recorded as well. For treatment, the participants received four hours per week of group treatment. Participants worked on conveying messages, initiating conversation, building confidence, and increasing self-awareness of the disorder.

Post tests were given after two and four months of therapy and four to six weeks after therapy concluded. The data showed that participants with severe aphasia improved twenty to thirty points on the CADL. The researchers also looked at clinical significance. Clinically significant changes include improvement of at least ten percentile points on the SPICA and five points on the WAB. In the immediate treatment group, six of the twelve participants made clinically significant changes on the SPICA after four months of treatment. In the deferred treatment group, only one of the eleven made clinically significant changes on the SPICA after going to only other social activities. Likewise, seven of the twelve participants in the immediate treatment group made clinically significant changes on the WAB compared to three of the eleven in the deferred treatment group. In addition, there was no significant drop in scores when the immediate treatment group was retested four to six weeks after treatment concluded.

These results show that group treatment was more effective than just social interactions. The data also indicates that four hours of treatment per week for four months was an effective amount for aphasic individuals. Participants and family members reported a great increase in confidence and initiation of conversation. Several participants reported socializing with other

people for the first time in years. One individual, who was previously scared to communicate with strangers, built up enough confidence to take a pair of shoes that did not fit him back to the store to exchange them. Questions that the researchers wish to answer in further studies are “Would participants make similar improvements with less therapy per week?” and “What aspects of the group treatment was responsible for the positive effects?” Overall, this study supported the use of group therapy for individuals with aphasia (Elman & Bernstein-Ellis, 1999).

These two studies both indicate the importance of group treatment for aphasic individuals. While Wertz’s study did not show significant differences in numbers, there were improvements seen in the individuals that participated in group treatment. The numbers from the second study show the increase of test scores after group treatment. The individuals who participated in group treatment improved in confidence and communication. After considering this research, speech pathologists will be equipped to select an appropriate therapy plan.

Now, as professionals consider what therapy model should be utilized for clients with aphasia today, functional goals remain at the forefront. One popular idea is the *Psychosocial Model*. This model takes all affected aspects of life into consideration such as personality, human nature, and emotional needs. Language difficulties are still the main focus; however, there is more importance on generalizing things learned in the therapy room to the client’s natural environment. Activities used in therapy are relevant to real-life situations in the client’s life. There is also an emphasis on social communication and interaction (Sarno, 2004). This model places importance on regaining communication through social situations.

Another option is the *Life Participation Approach to Aphasia Model*. This model continually assesses barriers in the client’s life which allows the therapist to form goals that will

combat the barriers. Examples of barriers are deficits in memory, cognition, language, and self-esteem. According to this model, goals should enhance attitudes and feelings, social interactions, and participation in activities. These goals should all work to enable the client as well as the client's family and friends. A second part of this therapy model is coping treatment which involves working through emotional barriers. Because language is so dramatically affected, the client may become discouraged by the reactions of those around him or her. Other people may not understand how to communicate with the client any longer. Coping treatment allows the client to overcome any discouragement (Lyon, 2004). This model works to combat barriers in all aspects of life.

Use of Book Clubs as Group Treatment

Several therapeutic programs have considered the effects of aphasia as well as the research on group treatment and decided that an appropriate method for therapy would be a book club. Book clubs allow the individuals with aphasia to work on several skills while enhancing social communication. Skills that would be targeted include reading, writing, and comprehension. Coming together as a club would allow the individuals to communicate with others who have the same difficulties. This allows a safe place to build not only communication but also confidence. Many book clubs for aphasic individuals have been created throughout the country; the following are three examples of programs that have utilized book clubs.

The Aphasia Center of California took the idea of using a book club as a therapy method and transformed it into Book Connection™. The clients at the center informed staff that they missed reading for pleasure. This sparked interest in the staff as they began to ponder how to create a book club that was appropriate and fun for people with aphasia. After forming a list of

books and “reading ramps,” the Aphasia Center of California began its program. The staff placed flyers around the center displaying the book chosen as well as the day and time of the meetings. Once a group of five to ten clients were signed up, the book club meetings could begin. The book club consisted of reading the text and interpreting it in addition to discussion sessions.

In order to assist the clients in reading the text, the staff used reading ramps. A reading ramp is defined as “modifications and strategies that make information accessible to people with aphasia” (Elman & Bernstein-Ellis, 2006, p. 33). These reading ramps include audiotapes of the book, large print books, and worksheets with chapter highlights and summaries. Audiotapes are important for clients who are unable to read due to vision or other medical problems. Large print books assist all clients with clarity of text. Chapter highlights and summaries are available for clients to review before or after the book club meetings. These ensure that the clients comprehend the main points of the reading. A major reading ramp is the weekly worksheets provided for the clients which are adapted into three levels according to the individual’s abilities. The first level includes multiple-choice questions about the chapters read. The second level involves questions that require a single word, short phrase, or picture answers. Lastly, the third level requires the client to provide sentence or paragraph answers. The client is able to choose the level at which he or she wishes to work. These worksheets are not required but are still given to each member of the group. Reading ramps serve the purpose of enhancing the client’s comprehension and participation.

After reading the text with or without the assistance of reading ramps, the club meets again to discuss the topics in the book. These discussion sessions are the most important part of the therapy method because they encourage communication in a social setting. Many people with aphasia struggle socially due to their language difficulties. This is combatted with the safe

environment of the book club allowing members to attempt and rebuild communication abilities. The staff of Book Connection™ also makes an emphasis on connecting the book with personal experiences of the members. Clients are encouraged to share their reactions from the book and tell any stories that relate to its content (Elman & Bernstein-Ellis, 2006). Programs such as Book Connection™ are a necessary addition to traditional therapy.

Following the lead of the Aphasia Center of California, several other rehabilitation centers have started book clubs for clients with aphasia. One of these centers is the Rehabilitation Institute of Chicago, which opened a book club in 2004. This program also includes a wide variety of ages and levels of abilities. Speech-language pathologists and volunteers come together to select a book and run the weekly meetings. These meetings include discussing topics related to the plot. This book club uses support methods such as chapter summaries and thought-provoking questions to assist the clients while they read. Another support for clients, the Free Talking Book Program, is available at the public library. This allows clients to check-out the digital book and digital book player in order to listen to the chapters. Clients have also found the digital books helpful because they are able to rewind and listen to sections they did not comprehend again. In the discussion sessions, clients are encouraged to share their reactions to the chapters. If they are unable to verbally communicate, they are encouraged to draw, gesture, or use augmentative communication (Rehabilitation Institute of Chicago, 2014). The Rehabilitation Institute of Chicago is providing valuable, dynamic therapy for clients with aphasia.

Jennifer Triandafilou, a certified speech-language pathologist who has worked with stroke survivors for over six years, also started her own book club, Reading for Life, in 2001 as an extension of her private practice in Rockville, Maryland. This club is comprised of four to

five members of different ages but similar level of abilities. These members typically display mild to moderately-severe aphasia. Once the book has been selected, Triandafilou sends out a packet complete with the title of the book and a study guide. Members use the study guide to take notes, answer the short answer questions, or answer multiple choice questions. There are several options in the packet depending on what the member prefers to do. All of the options encourage members to comprehend the material and practice writing skills. The club then meets once a month for ninety minutes to review the book, discuss the themes, and rate the book. Triandafilou has seen great improvement in the member's speech, language, and social skills through this program. She hopes that the program will continue to grow in the following years (Triandafilou, 2003). Reading for Life has positively impacted individuals with aphasia.

Evaluation of Book Clubs as Group Treatment

By analyzing these programs, strengths and weaknesses of aphasia book clubs can be discovered. The biggest strength is the enhancement of social communication. Humans are meant to be social and feel a sense of isolation if they are not able to socialize. This can negatively impact an individual's emotional and mental well-being. As individuals with aphasia experience language difficulties, it is imperative to continue to encourage social interaction. In addition, using a variety of supports for the members of the book club has proven to be beneficial. Aphasia can be different for each person; therefore, there needs to be a support or "reading ramp" for each individual.

Another strength is that book clubs allow the members to participate in a normal daily activity again. Reading for pleasure is something that most people enjoy. This simple task may become difficult for individuals with aphasia depending on the severity. Books clubs help these

individuals to regain this activity. In addition, the programs previously described select books that relate to the member's age or lives. This helps the individuals become interested in the content which is a necessary factor in the success of the book club. Lastly, as Wertz's study showed, group therapy is cost effective. Book clubs, a form of group therapy, allow speech pathologists to work with aphasic individuals within the limits of insurance reimbursement policies. Based on the amount of strengths, books clubs can be said to be beneficial for individuals with aphasia.

One weakness in the Rehabilitation Institute of Chicago and Jenifer Triandafilou's programs is that the sessions did not include reading the text. It would be more beneficial to the group members if the text was read during the session because the speech pathologist would be available to assist them if necessary. Although the reading ramps are very helpful, members may need face-to-face assistance. Reading skills would be improved if some of the sessions involved reading the text. Another weakness of book clubs in general is that group therapy may not allow the speech pathologist to give equal attention to each member. With groups from five to ten, the speech pathologist structures sessions differently than individual sessions. The speech pathologist must work diligently to ensure that each member receives the appropriate attention and therapy. These two weaknesses should be considered before creating an aphasia book club.

There are also a couple of improvements that could be made to the current book clubs. For instance, some of the book club sessions should include reading the text aloud. This would not only enhance reading skills but also confidence. The speech pathologist could understand at what level the individual's reading is if reading aloud were part of the sessions. Then, the speech pathologist could better help the individual improve on areas of difficulty. Since the book club is a safe environment, reading aloud would improve the individual's abilities.

A second suggestion would be to videotape the book club session so long as the members give permission to do so. This would allow the speech pathologist to go back and review what has been done in order to see what areas need to be given more attention. Videotaped sessions could also be used as encouragement for the individuals with aphasia. Often, individuals with aphasia become discouraged because it may be difficult for them to see the small improvements they are making. These improvements may be baby-steps that lead to larger changes. The members of the book club could go back and watch the videotapes from the first couple of sessions to realize the improvements they have made. It is important to continually encourage these individuals as improvements may not always be evident. Videotaping sessions would benefit both the speech pathologist and the individuals with aphasia.

Thirdly, each book club session should have a written or picture schedule for the members. This schedule would include the agenda for the day and potential topics of discussion. A schedule would give structure to the sessions which would help the members follow along and contribute to the conversation. An example of a written schedule would include a welcome, a list of chapters that will be discussed, questions for each chapter, and a list of topics that relate to the chapter. An example of a picture schedule would include a picture of a person waving hello, numbers of the chapters that will be discussed, and pictures that relate to the chapters. These schedules are an important tool to assist members in understanding what will happen during the sessions.

A final improvement would be to have the members of the book club express their feelings regarding aphasia at the end of each session. They could discuss recent difficulties they are having, any discouragement they are feeling, improvements they have noticed, or new experiences they have had. This could allow the group to not only improve on social

communication, but also improve on coping with the condition. Because all members are dealing with aphasia, they would be able to support and encourage each other based on the feelings shared at the end of the session.

Although aphasia involves deficits in several areas, there are methods to successfully treat and cope with language difficulties. Speech pathologists and other health care related professions have worked to incorporate evidence based practice in all aspects of their practices. Research has shown that group therapy greatly benefits individuals with aphasia. Many therapeutic centers have introduced the idea of a book club as group treatment for individuals with aphasia. The current programs show many advantages such as providing a cost effective way to enhance social communication through a pleasurable activity. By considering the potential weaknesses and improvements that could be made, book clubs could become the most beneficial group therapy method for individuals with aphasia.

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